Urgent Care- Improving Patient Flow. The Gateshead Approach

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Presentation Overview

- A bit about Gateshead
- Gateshead Care Partnership
- Patient Flow is everyone's business
- The Gateshead Way
- Gateshead don’t have all the answers…
- Questions?

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Where is Gateshead?

BURGER KING

BALTIC CENTRE FOR CONTEMPORARY ART
EXHIBITIONS FAMILY FUN FOOD & DRINK SHOP
BALTIC

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Gateshead Demographics

- Gateshead is 142 sq km in size with a population of approx 210,000. (There is a large student population.)
- In 2017 in Newcastle and Gateshead the 65-84 year old population is : 69,183, with 10,344 people aged 85 years and over.
- It is predicated in 2037 the 65-84 year old population will be 89,246 which is an additional 20,063, a rise of 29% and the 85 years and over population will rise to 19,964, a 97% increase.

What is Gateshead Care Partnership?

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Why have a partnership approach?

- Focussed on Gateshead's needs
- Shared goals
- Shared vision
- Recognises the key role of GP practices in Primary Care
- There is no inclusion or exclusion criteria for Gateshead GP registered patients
- Removes professional and organisational boundaries boundaries
- Removal of duplication
- Seamless care for Gateshead residents
- Offers opportunity for prevention of ill health for all Gateshead population

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Patient Flow is everyone's business

- Weekly meetings of senior decision makers from all partners to “unblock” any bottlenecks
- Honest conversations-patient first- to get patients to the right place at the right time with staff with the right skills looking after them
- Daily/Weekly meetings of operational staff to manage flow and Dtoc’s
- All patient in a hospital bed aim to be discharged home in the first instance
- Revised Intermediate Care criteria to support enablement and step up/step down
- Increased capacity into 24/7 rapid response Urgent care team (community based)
- Increased capacity into OOH GP service- working collaboratively with Urgent Care team and Primary Care

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The Gateshead way…

- Community Intermediate Care team giving IV's as part of the cellulitis pathway
- Use of Expected Date of Discharge (EDD)
- Reviewing stranded patients (7 days >)
- Clinical criteria for Discharge- Transfers of care
- Board round checklist
- Optimised MDTs- acute and community
- Allocated funding into Residential or Care homes for step down facilities "bridging service" and pressure placement beds

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The Gateshead way continued.....

- Discharge Liaison nurses working into front of house-discharge planning from admission
- Use of the Trusted assessor model
- Frailty nurses working front of house
- Use of the Older persons nurse specialists in Care Homes- emergency health care planning (EHCP)
- Planned pump primed funded domiciliary carers in the community to support early discharge for 4 months over “winter”

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- Local authority Web form referral pilot to reduce handover time
- Community Matrons attending Board rounds at least weekly in the hospital
- Care home engagement and development – EHCP/OPNS/Frailty nurses
- Direct access/referrals to PRIME- the LA rapid response domiciliary care service
- Pharmacist Hub (trial) to support at scale follow up model to avoid readmission
- Flexible Intermediate care beds and Assessment beds with MDT agreement in LA facilities

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Thank You

Any Questions?

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